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The Role of Social Drivers of Health within Hospital Rating Programs

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What's Inside:

Publicly reported program rankings for U.S. hospitals and health systems are gaining prominence—serving as crucial benchmarks to assess performance across quality, operational, and financial metrics in comparison to peers.

Consumers frequently rely on these rankings when making healthcare choices and national insurers provide incentives for consumers to select providers that meet certain cost and quality benchmarks.

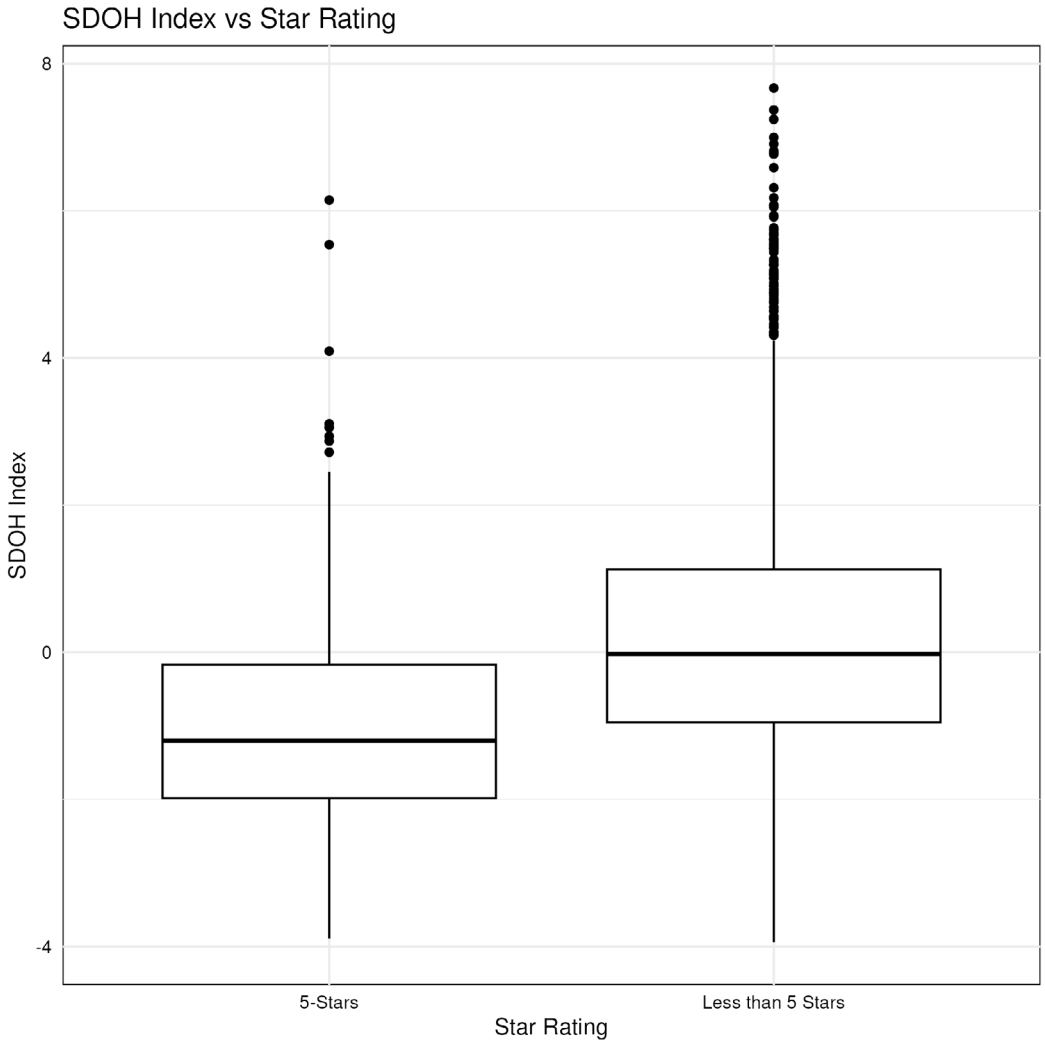
As such, these programs are progressively evolving into a "north star" for hospital management and boards in developing a strategy for managing total performance in a transparent, scorecard world. But do these ranking programs accurately reflect all the complexities of the patients served? This article explores the impact social drivers of health (SDOH) can have on ratings, efforts underway to modify rankings programs to account for disparities, and leadership considerations for fair benchmarking.

The Impact of SDOH on Ratings

There is general consensus across published research that the social and environmental circumstances of patient populations are important factors to consider when evaluating health outcomes. Despite the depth of research supporting inclusion of SDOH within health outcomes evaluation, these measures are largely absent from both public and private hospital ratings programs. As an unfortunate consequence, hospitals serving more marginalized populations have an inherent disadvantage in many ratings programs, which can affect a hospital's reputation and, in the case of CMS pay-for-performance programs, a non-trivial portion of Inpatient Prospective Payment System (IPPS) reimbursement.

Exhibit 1 provides a representative example of such performance disparity, where an SDOH index comprised of recently released beneficiary characteristics from CMS (including factors such as dual eligibility, low-income subsidy, ICD-10 Z coding of SDOH, behavioral health codes, and area deprivation index risk) is evaluated against top performers in the CMS Overall Star Ratings program. Here it can be seen that hospitals with greater SDOH risk generally perform less favorably within the CMS 5-Star rating program.

Exhibit 1: CMS Overall Star Rating Status by SDOH Index



Program Modifications Are Underway to Address SDOH

CMS is keenly aware of these challenges. In 2012 (FY 2013), it modified the Hospital Readmissions Reduction Program to implement benchmarks based on dual-eligibility tiers rather than a population-wide benchmark. Other efforts within CMS are underway to improve fairness of such programs from an SDOH perspective by both reporting within

various SDOH categories or accounting for the variances in their public measures. In line with that, a recent National Quality Forum (NQF) report on risk adjustment methodologies was modified from a previous version to consider using SDOH when appropriate for the measure and context for which that measure is used.[1] Private ratings programs are also taking action with the PINC AI™ 100 Top Hospitals® study currently under revision to recognize hospitals providing equitable care.

Until ratings programs are modified to account for SDOH, a hospital's perception of their performance can be skewed, regardless of the patient populations they serve. Without accounting for SDOH factors, a hospital serving a higher proportion of disadvantaged patients may have performance scores biased in an unfavorable direction—as the increased risk of their patient population is undetected through the program design. Similarly, hospitals serving a low proportion of disadvantaged patients may have performance scores biased in a favorable direction, due to the undetected reduction of risk within their patient populations.

As a result, hospitals and health systems may struggle to obtain a fair comparator against which to evaluate their own performance within such ratings programs. A useful strategy to identify more robust benchmarks is through the curated set of facility peers based on the distribution of SDOH characteristics.

Key Board Takeaways

- **Rising significance of program rankings:** Publicly reported ranking programs are gaining traction in management and board discussions, serving as vital benchmarks for assessing performance in various metrics, including quality, operational efficiency, and finances.
- **Consumer influence:** Hospital rankings also play a crucial role in shaping consumer choices regarding healthcare services.
- **Absence of SDOH in rankings:** Despite the acknowledged importance of social and environmental factors in healthcare outcomes, existing ranking programs largely overlook SDOH metrics. This omission creates disparities, impacting the reputation and reimbursement of hospitals, particularly those serving more marginalized populations.
- **Efforts to address SDOH:** CMS has recognized the challenges and implemented modifications, such as dual-eligibility tiers in the Hospital Readmissions Reduction Program, to address SDOH concerns. Private programs are also following suit.
- **Stratification for fair benchmarking:** Stratification based on SDOH indices can serve as a tactical approach for transparent and fair benchmarking.

1 "NQF Offers Guidance for Risk Adjusting Social and Functional Risk Factors in Healthcare Quality Measurement" (press release), December 21, 2022.

Stratification for Fair Benchmarking

Tactically speaking, stratification can be facilitated using an index value, which has the convenience of compressing multiple aspects of SDOH into a singular composite. Some notable SDOH metrics include the social vulnerability index and area deprivation index as well as more direct measures such as dual eligibility, which has been historically favored by CMS. It is important to note, however, that not all indices are equal—and healthcare boards and senior leaders are encouraged to work with their analytics team to ensure that the employed index is fair and appropriately captures risk that aligns with the organization's goals.

Hospitals that compare performance against an SDOH peer group will have more objective and meaningful benchmarks to compare against.

Hospitals that compare performance against an SDOH peer group will have more objective and meaningful benchmarks to compare against. For example, a hospital serving a largely disadvantaged patient population may be providing exceptional care relative to its peers (shown through risk-adjusted outcomes), but relatively low performance across the larger facility population. The contrary scenario may also occur, whereby high-performing facilities in affluent neighborhoods may not be so exceptional when evaluated against hospitals serving patients with similar social and environmental circumstance. As such, stratification by an SDOH index provides important context around the patient populations that those facilities serve.

While it is recommended that healthcare organizations compare hospital ranking results against a peer group that considers SDOH factors to produce a more informed benchmark, there is significant work remaining from a policy perspective to mitigate inherent bias within these programs.

Board Discussion Questions

- Is management taking SDOH into account when evaluating hospital rankings?
- How is our hospital/system performing relative to peers with similar SDOH characteristics?
- If an SDOH index is being used in hospital benchmarking (e.g., stratification), does the team have an in-depth understanding of how the index is formulated and its potential challenges?

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It's Time to Take Digital-First Consumerism Seriously in Healthcare

By Chong Li, Elias Kassis, and Angel Valladares, Real Word Evidence and Healthcare Innovation Experts, *IQVIA*

The COVID-19 pandemic accelerated the digitization of healthcare data and processes, as well as consumer expectations, leading to a paradigm shift in how patients seek and engage with healthcare providers.

Mainly via digital methods, patients are taking a digital-first approach and are making healthcare decisions based on knowledge acquired through online information available via consumer platforms, crowdsourcing, and direct-to-patient advertising.[1] This is impacting the entire patient journey, from as early as a patient's initial steps to inform themselves on their symptoms and possible options, to searching for care and selecting their providers, to interactions during care delivery, through relevant follow-up and long-term care coordination. While these dynamics have enabled a more participatory patient experience, they have also generated new risks and challenges for traditional health systems.

Notably, this digital-first consumerism shift has led to the initial emergence of disruptive stakeholders in primary care like Amazon's One Medical and CVS Health.[2] These relatively new entrants into healthcare delivery implement care models that significantly deviate from traditional practices. By providing tech-enabled patient engagement, convenience, and cost-competitive services, they are positioning themselves to leapfrog traditional health systems leveraging massive amounts of available capital and infrastructure.

Consequently, health systems will need to capitalize on the opportunities and mitigate the respective risks provided by growth in healthcare consumerism to remain competitive against new consumer-focused entrants that are setting new patient expectations.[3] The more successful strategies consider investments in online patient portals and chatbots, telehealth platforms, and at-home diagnostics that can enable cost-effective, convenient, and quality care.[4]

Through the lens of a patient's traditional healthcare journey, this article explores illustrative examples of health systems that are embracing digital solutions to better position themselves in the era of expanding healthcare consumerism.

1 Sung-Yeon Park, et al., "Patient-Centered Care and Healthcare Consumerism in Online Healthcare Service Advertisements: A Positioning Analysis," *Journal of Patient Experience*, October 2022.

2 Eric Wicklund, "Assessing the Biggest Disruptors in Healthcare," HealthLeaders, February 20, 2023.

3 Erin Ney, Eric Berger, and Sharon Fry, "Primary Care 2030: Innovative Models Transform the Landscape," Bain & Company, July 11, 2022.

4 "Payers Need Digital-First Innovation to Meet Consumer Expectations and Stay Competitive," Medecision, March 14, 2023.

Evolving Digital-First Consumerism throughout the Patient Journey

Self-Education and Pre-Visit Preparation

As patients seek care like consumers, they have rising expectations for transparency, information, value, and their overall experience. Thanks to broader growth of the digital-first economy in non-healthcare settings, patients now have a myriad of platforms and information systems at their disposal to inform themselves in advance of their appointments. With these types of solutions, healthcare consumers can be met at their level of comfort with technology, health literacy, and personalized preferences for a "digital front door" to their care. Online patient portals are a way to offer personalized checklists, pre-visit reminders/questionnaires, and health education materials to ensure patients are informed and engaged in advance of their appointments. For instance, a digital patient portal accompanied by an AI chatbot trained on specific medical and health databases at UC San Diego Health has demonstrated tangible benefits and support during visit preparation.[5] All in all, it can be an opportunity to build and reinforce the patient–provider relationship in a way that is less burdensome to the provider, allowing for more engaged patients.

Care Searching and Scheduling

For healthcare consumers, engagement with a health system typically begins with seeking suitable providers that may address noticeable symptoms or ideally provide guidance on preventive practices. However, as significant research has indicated, this has not been a seamless or straightforward process for either patients or providers and drives further disparities in terms of access to care.[6] Thankfully, creative solutions that better align with the innovation spurred by the expansion of consumerism in healthcare brought about by tech disruption are making waves. In New York City, a consortium of health systems including Weill Cornell Medicine, New York Presbyterian, and Columbia University Irving Medical Center have deployed NYP Connect. This customizable patient portal/mobile app, supported by Epic, provides patients with critical information including availability of insurance coverage, wait time of specific specialists, patient satisfaction ratings from prior encounters, and hospital transportation information.[7] NYP Connect can help patients seek the care best aligned with their expectations and anticipated needs across multiple area health systems. Once a patient decides on whether to seek care, the digital scheduling system embedded in the portal can simplify the process of making appointments, managing referrals, and preparing documents.

5 Patrick Boyle, "How AI is Helping Doctors Communicate with Patients," AAMC, August 8, 2023.

6 John Matulis and Rozalina McCoy, "Patient-Centered Appointment Scheduling: A Call for Autonomy, Continuity, and Creativity," *Journal of General Internal Medicine*, February 2021; Walter Hsiang, et al., "Medicaid Patients Have Greater Difficulty Scheduling Health Care Appointments Compared With Private Insurance Patients: A Meta-Analysis," *INQUIRY*, January–December 2019.

7 For more information, see www.myconnectnyc.org.

Receiving Care

Providers have expressed significant discomfort with the encroachment of transactional-focused systems, which are at the core of consumer-oriented service delivery.[8] On the other hand, patients have voiced their declining trust in the healthcare system, and experts attribute that erosion in trust to several factors including rising medical debt, data breaches, the spread of misinformation, and lack of personalization.[9] All in all, it's clear from countless surveys that an array of different solutions will be necessary to bridge the growing gap between providers and their patients.[10] To that end, patients are seeking new ways to access and engage in their care, including being more open to virtual and personalized care delivery.[11] Importantly, using a combination of synchronous (e.g., scheduled telehealth appointments) and asynchronous (e.g., remote monitoring) virtual care services may enhance the experience for both the patient and the provider.

Telehealth has been bolstered as a critical solution to fill a myriad of gaps. One argument is that it can allow patients who live in areas with provider shortages to receive more efficient and convenient care. Further, changes to government regulations resulting from the COVID-19 pandemic have enabled combinations of telehealth and at-home diagnostics to complement in-person care.[12] Some of these services are already showing their promise. Telestroke, a two-way video conferencing service for stroke care, has successfully reduced the time needed for rural stroke patients to get the clot-dissolving treatment alteplase, providing convenient and life-saving care.[13] While the jury is still out on whether virtual care is truly closing access gaps,[14] health systems do have opportunities to more thoughtfully adopt virtual care tools like telehealth and patient portals in a way that helps address the potential downsides of a digital-first patient experience.[15]

Follow-up and Ongoing Care Management

Health systems notoriously struggle to maintain patient engagement and ongoing care management post-treatment. As with earlier phases of the patient journey, tools designed to proactively monitor patients with certain risk profiles and follow-up needs promise to fill the gaps left by traditional models of reactive human coordination. Integrated health systems and provider networks are turning to centralized platforms enabled by health IT vendors to improve follow-up and care management. These internal data-sharing platforms can support care coordination and follow-up for some of the most complex patient populations, including behavioral health.[16] In addition to internal tools that can improve the coordination abilities of health systems, patient-facing apps that leverage AI can provide for a personalized experience that can maintain patient engagement.

8 Timothy Hoff, *Next in Line: Lowered Care Expectations in the Age of Retail- and Value-Based Health*, Oxford, UK: Oxford University Press, 2017.

9 Paul Keckley, "U.S. Healthcare's Existential Threat: Loss of Public Trust," *The Keckley Report*, October 16, 2023.

10 Jenny Cordina, et al., "Patients Love Telehealth—Physicians Are Not So Sure," McKinsey & Company, February 22, 2022.

11 Donna Marbury, "How Specialty Care Is Leading the Change in Telehealth," *HealthTech*, November 30, 2023.

12 "Telehealth Policy Changes after the COVID-19 Public Health Emergency," HHS.

13 "Telehealth in Rural Communities," CDC.

14 Jack Eastburn, et al., "Is Virtual Care Delivering on Its Promise of Improving Access?," McKinsey & Company, January 9, 2023.

15 Kevin Johnson, et al., "Ensuring Equitable Access to Patient Portals—Closing the 'Techquity' Gap," *JAMA Network*, November 10, 2023.

16 Bill Siwicki, "Patient Follow-up Rate at Mental Health Network Soars with Care Coordination Tech," *Healthcare IT News*, June 7, 2019.

One example can be found in an AI chatbot service provided by Northwell Health called "Pregnancy Chats," which offers personalized dialogue customized to engage based on a patient's medical history and treatment.[17] The chatbot serves as both an educational program and an innovative care service that can help patients notice subtle changes earlier, leading to sooner detection of postpartum complications. The chatbot is linked to the care management team to enable immediate escalation for clinical care if needed and data on the service demonstrated strides both in patient satisfaction and clinical impact. It's an example of taking a comprehensive approach to patient engagement that empowers and enables the care team, but also improves the experience for the patient.

Healthcare consumers can be met at their level of comfort with technology, health literacy, and personalized preferences for a "digital front door" to their care.

Key Board Takeaways

- Health systems have the opportunity to optimize tech-enabled patient engagement, convenience, and cost-competitive services to better position themselves against new disruptor stakeholders that are becoming competitive threats to traditional provider organizations.
- The more successful strategies embracing this digital-first consumerism consider investments in online patient portals and chatbots, telehealth platforms, and at-home diagnostics that can enable cost-effective, convenient, and quality care.
- Health systems should leverage their large datasets to better understand their patient populations and better tailor their investments in consumer-oriented solutions.
- With these types of solutions, healthcare consumers can be met at their level of comfort with technology, health literacy, and personalized preferences for a "digital front door" to their care.

How the Consumer Experience in Used Auto Sales Can Show the Way

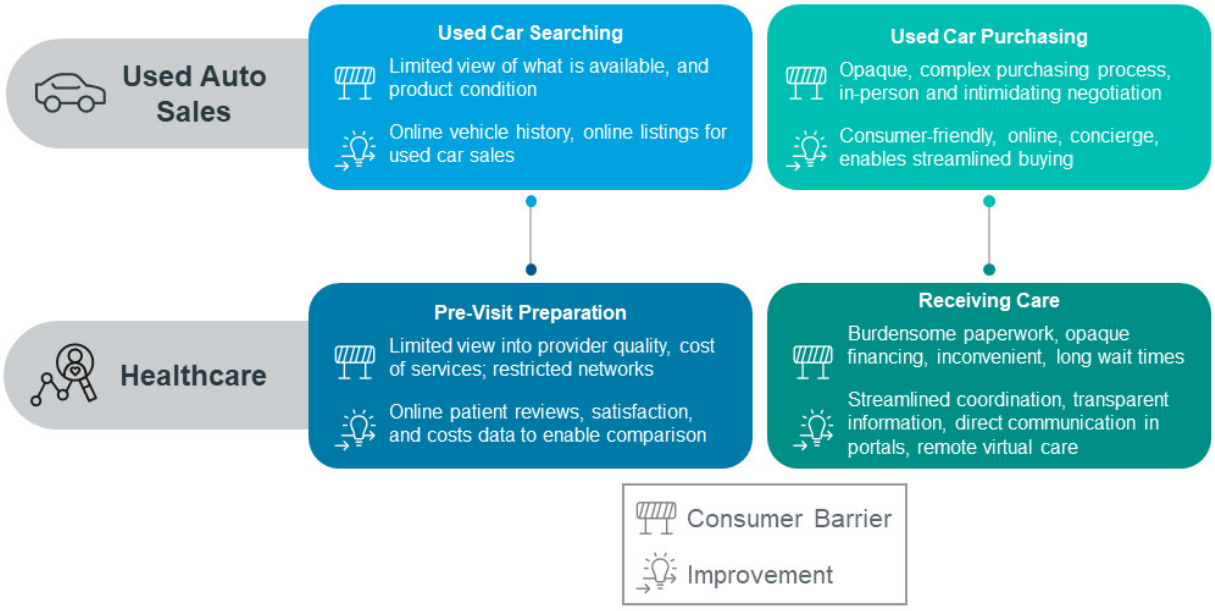
Historically Opaque and Complex Navigation for Consumers

To find an example of how shifting dynamics in the consumer experience disrupted other formerly opaque markets, one can look to used auto sales. The used-car industry is one notable example where online services and information hubs have addressed the notorious inefficiencies that plagued consumers. Historically, consumers often possessed

17 Lisa Davis, "Northwell Releases AI-Driven Pregnancy Chatbot," January 11, 2023.

limited information about vehicle condition, relative market price, and financing options before making a purchase. Moreover, it was infeasible to comparison shop beyond physical browsing of available used vehicles at a finite number of local dealerships. The risks of purchasing a "lemon," limited selection, and opaque financing information draws several parallels to some of the challenges reported by patients in traditional models of healthcare services.

Exhibit 1: Drawing Parallels between Consumerism in Healthcare and Used Auto Sales Markets



In the used auto sales industry, disruptors such as Carvana and CarMax that leverage digital technologies to provide a superior consumer experience have significantly transformed and dominated the market in a relatively short amount of time.[18] Similarly, in the face of rising prominence of retail healthcare services, health systems must integrate digital technologies to stay competitive. This integration not only allows buyers to better navigate the market, but also provide significant second-order benefits to sellers. The wider-reach and increasing trust brought by online platforms have increased the sales volume and reduced vehicle time on lot, which is crucial for the dealership business model. The data generated from online platforms also enables dealers to better understand market trends and consumer preferences, allowing for targeted marketing and efficient inventory management. Post-sales service and maintenance reminders can nudge buyers to return for regular servicing, which fosters customer loyalty while generating consistent revenue streams.

18 "A Tech-Enabled Approach Is Accelerating Automotive Ecommerce Growth," RBC Dominion Securities Inc., December 20, 2023.

The Takeaway: Expansion of Digital-First Consumerism in Healthcare Is Unstoppable

Digital tools have demonstrated their remarkable capacity to transform and enhance consumer experiences in even the most complex and difficult markets. By broadening information access, streamlining processes, and facilitating personalized interactions, these technologies can demystify and improve the consumer journey, whether in car sales, healthcare, or other markets. For health systems, the data are clear that patients, especially the next generation that will be in need of healthcare services, will be significantly more capable and inclined to using digital tools, and will want to access care closer to home and in their community.[19] However, given that adoption will vary significantly by the communities being served,[20] health systems should leverage their large datasets to better understand their patient populations and better tailor their investments in consumer-oriented solutions. Lessons learned from primary care and personalized care coordination, as shared in the examples above, can provide insights to health system boards and senior leaders looking to remain competitive in this quickly shifting market.

The Governance Institute thanks Chong Li, Elias Kassis, and Angel Valladares, Real Word Evidence and Healthcare Innovation Experts from IQVIA, for contributing this article. Please reach out at angel.valladares@iqvia.com with any questions.

19 Szoa Geng, et al., "Health Care's New Reality Is Dynamic, Digital—and Here to Stay," Boston Consulting Group, December 15, 2021.

20 "3 Digital Health Trends That Are Transforming Patient Care," AMA.

Determining Your Medicare Value-Based Strategy for 2025 and Beyond

By Eric Weaver, D.H.A., M.H.A., FACHE, FACMPE, FHIMSS, Vice President, *Lumeris*

The Opportunity Is Now

Now is the time for hospital and health system governing boards to fully commit to a value-based care transformation strategy. Economic models and structures that align with the reorganization of care delivery to two-sided risk contracts are a strategic lever for amplifying upside opportunities in both clinical and financial transformation. Waiting on the sideline altogether, or just delaying the full optimization of your risk-based revenue portfolio in the Medicare fee-for-service program, can have deleterious effects on long-term solvency and prolong critical transformation in care delivery. By capitalizing on this open window to join the **Medicare Shared Savings Program (MSSP)** or the **ACO Realizing Equity, Access, and Community Health (REACH) Model**, your health system will be positioned to not only mend the sick but invest in the well-being of your communities, forging a foundation for financial stability through proactive and preventive care. Participation in MSSP or ACO REACH will also serve as a testing ground for readiness in value-based practices, aligning with CMS's ambitious goal of having 100 percent of traditional Medicare beneficiaries in accountable care relationships by 2030.

The Bigger Picture for Value

The sense of urgency for value-based payment adoption could not be more imperative in the short term, as it represents not only a pivotal shift towards a more sustainable and patient-centric delivery system but also a decisive step in aligning incentives for providers, payers, and patients, fostering improved outcomes, cost-effectiveness, and overall healthcare excellence. Accepting calculated financial risk in the Medicare fee-for-service program is a daunting scenario for many boards when value-based readiness is not fully optimized; therefore, alignment consideration with a partnering influencer may be warranted to provide population health enablement expertise and cutting-edge technology to ensure strategic capitalization of upside potential and mitigation of downside risk exposure.

A fully informed governing board must recognize that the current environment of highly concentrated fee-for-service revenue is not sustainable. Mounting pressures to shift towards value-based payment should not be overlooked, given the opportunity for strategic positioning in the provision of high-quality care, care coordination, and enhanced population health management. Alternative payment models, like the MSSP or ACO

REACH, provide a pathway to thrive in a changing healthcare landscape, encouraging a focus on preventive services, chronic disease management, and overall patient wellness.

Key Board Takeaways

- For health systems newer to value-based care that are getting their feet wet in managing total cost, MSSP remains a strong option as it has guardrails and policies in place to protect participating organizations and provides ample opportunity to achieve shared savings. However, organizations should regularly evaluate the performance of their network at the NPI level to determine whether providers are demonstrating the readiness to graduate to higher levels of risk with greater incentives. It is noteworthy that ACOs in two-sided risk models are more likely to achieve savings and have a higher average savings rate than their peers in upside only.
- ACO REACH is a strong option for provider organizations that have experience in value-based care and have the capabilities to meet the advanced requirements of the ACO REACH model. With the ability to include providers at the NPI level, ACO REACH can expose high-performing providers within networks to the highest level of savings while mitigating downside exposure. Of the available Medicare programs, ACO REACH is most like Medicare Advantage in its ability to generate significant savings and meaningful incentives for providers while incorporating options for benefit enhancements typically only found in Medicare Advantage that more closely align consumers to provider organizations.
- The time to act in formulating your value-based care strategy for 2025 and beyond is now. Boards must carefully evaluate the respective benefits and risks associated with participating or not participating in each of the value-based programs highlighted as the industry continues to evolve towards more mature levels of delegated risk sharing. Within large networks of providers, it is unlikely that a one-size-fits-all-approach to participation in these products will be successful in maximizing revenue opportunity and premium capture while minimizing downside exposure.

The 2025 Strategic Planning Process

Governing boards and C-suite leaders will need to decide which, if any, Medicare programs to participate in as they prepare to meet with their boards in May or June.

Fortunately, if leaders begin the planning process now, they can make the most informed decision about participation in the MSSP or ACO REACH value-based programs for the upcoming 2025 performance year.

The key to selecting the right program for your provider network will require:

1. Awareness of payment model design attributes specific to various MSSP tracks and ACO REACH, including upside opportunity potential balanced by downside risk exposure, benchmarking methodologies, benefit enhancements, capitation payment methods, and beyond.
2. A comprehensive understanding of the network's risk-adjusted performance conducted at the national provider identifier (NPI) level to better inform the overall appetite and readiness for moving towards fully delegated risk models.

If leaders select programs with downside risk that their network isn't fully equipped to handle, they risk having to foot a large bill to CMS during reconciliation the following year. Conversely, if they are over-cautious and select a program that offers too little upside opportunity for a system already on the value-based care transformation curve, they risk forfeiting significant earned savings to CMS and risk not having enough savings distribution for their network. The latter scenario of an overly conservative approach or "analysis paralysis" leading to undue financial risk aversion not only limits upside rewards, it poses an unintended consequence of losing aligned providers and beneficiaries to other networks, physician aggregators, and vertically integrated payers that provide access to total-cost-of-care models with the population health enablement capabilities to succeed.

The time to act in formulating your value-based care strategy for 2025 and beyond is now.

While many networks are looking to test out their value-based competencies and need a risk corridor buffer, market disruptors and clinically integrated networks with the resources and experience to successfully manage total cost of care are looking to capitalize on the significant investments they have made into population health to increase their access and capture of first-dollar risk. Primary care-centric organizations are looking to partner with their primary care providers in total-cost-of-care models, while large multispecialty groups and academic medical centers are seeking to optimize incentives for their specialists. If health systems and clinically integrated networks participating in value-based care choose to move their providers through the risk continuum uniformly, there will certainly be missed opportunities and greater potential for losses. With NPI-level participation available in newer CMS programs such as ACO REACH, options can and likely should be combined depending on organizational priorities and existing network makeup and infrastructure rather than the one-size-fits-all approach to contracting that is most common today.

Exhibit 1 provides a comparison between the MSSP and ACO REACH programs in alignment with key program dynamics to consider for your organization.

Exhibit 1: Program Comparison and Key Considerations

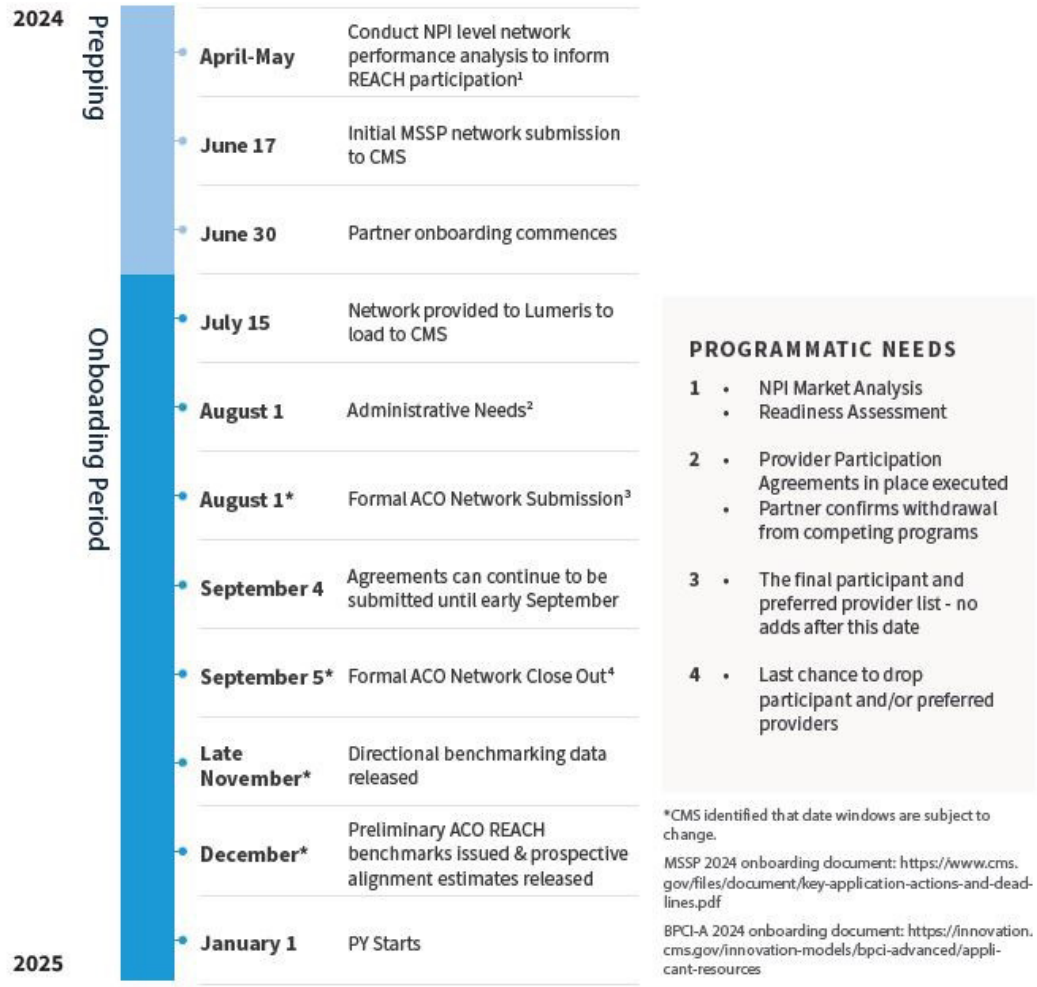
	MSSP	ACO REACH	KEY CONSIDERATIONS	
First Dollar Earning Opportunity	◐	●	M	40 - 75% x Quality Score once minimum shared savings rate (MSR) is met or exceeded. Depending on track an ACO could choose first dollar (no MSR)
			R	50% / 100% of first dollar savings after 3.5% CMS Discount, depending on Professional / Global track, no MSR
No Cap on Earnings / Losses	○	◐	M	Shared savings cap (Basic: 10% of updated benchmark, Enhanced: 20% of updated benchmark)/shared losses cap (Basic: N/A or 1-4% of updated benchmark, Enhanced: 15% of updated benchmark)
			R	Variable risk corridors depending on performance and Global/Professional track with option to purchase stop-loss from CMS
Advanced Alternative Payment Model Eligible	◐	●	M	Qualifies as AAPM in Track E or Enhanced only
			R	Qualifies as AAPM
MA-like Benefit Enhancements & Engagement Incentives	◐	●	M	SNF, Telehealth, Beneficiary Incentive Program
			R	NP, SNF, Home Health, Telehealth, Hospice, Post-Discharge, Cost-Sharing Support, CDM Reward Program, Vouchers for OTC Meds/Wellness Programs/BP Monitors
Downstream Payment Flexibility	○	●	R	Flexible primary and total care capitation
TIN / NPI-Level Segmentation	○	●	R	Participant/preferred providers contracted at TIN / NPI level and can be added or removed annually

KEY: M: MSSP | **R:** REACH | ● Yes | ◐ Maybe / Sometimes True | ○ No

Medicare Program Timeline for 2025 Participation

Exhibit 2 provides a timeline for applying for and joining the MSSP and ACO REACH programs.

Exhibit 2: Medicare ACOs (REACH and MSSP)



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